

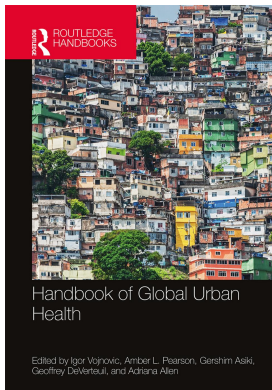
This article was downloaded by: 10.2.97.136

On: 30 Mar 2023

Access details: *subscription number*

Publisher: *Routledge*

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London SW1P 1WG, UK



## **Handbook of Global Urban Health**

Igor Vojnovic, Amber L. Pearson, Gershim Asiki, Geoffrey DeVerteuil,  
Adriana Allen

### **Refugees and Health in Urban Africa**

Publication details

<https://test.routledgehandbooks.com/doi/10.4324/9781315465456-24>

Sheru Wanyua Muuo

**Published online on: 20 May 2019**

**How to cite :-** Sheru Wanyua Muuo. 20 May 2019, *Refugees and Health in Urban Africa from:*  
Handbook of Global Urban Health Routledge

Accessed on: 30 Mar 2023

<https://test.routledgehandbooks.com/doi/10.4324/9781315465456-24>

**PLEASE SCROLL DOWN FOR DOCUMENT**

Full terms and conditions of use: <https://test.routledgehandbooks.com/legal-notices/terms>

This Document PDF may be used for research, teaching and private study purposes. Any substantial or systematic reproductions, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The publisher shall not be liable for an loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

## 21

REFUGEES AND HEALTH IN  
URBAN AFRICA*Sheru Wanyua Muuo***Introduction**

Displacement of people from their homes or countries of origin has been happening for centuries. This is often triggered by human-made or natural calamities such as wars, human rights violations, environment and climate change, extreme poverty and terrorism among others. Displaced populations have been broadly categorized as refugees, internally displaced people, asylum-seekers and stateless people. According to the United Nations Convention and Protocol Relating to the Status of Refugees adopted in 1951, a refugee is someone who has fled their country of origin and is unable or unwilling to return to their country of origin due to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion (UNHCR 2010). Although related, internally displaced people, asylum-seekers and stateless people must be distinguished from refugees. While there is no official definition of an internally displaced person, the guiding principles on internal displacement set by the Office for the United Nations High Commissioner for Refugees (UNHCR) hold internally displaced persons to be

persons or groups of persons who have been forced to flee, or leave, their homes or places of habitual residence as a result of armed conflict, internal strife, and habitual violations of human rights, as well as natural or man-made disasters involving one or more of these elements, and have not crossed an internationally recognized state border.

*(United Nations 2001)*

An asylum seeker is a person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded (Refugee Council 2018). Stateless people are those who are not considered to possess the legal nationality of any state.

In 2017, out of 68.5 million people forcibly displaced worldwide, 25.4 million were refugees. Refugees have been hosted in different parts of the world including countries in Africa, Asia, Europe and the Americas, with low and middle income countries hosting 85% of the refugee population (UNHCR 2018). At the end of 2016, Africa alone hosted 5.6 million refugees and asylum-seekers, almost 13.2 million internally displaced persons (IDPs) and 715,000 stateless people (UNHCR 2016). During the same period, the sub-Saharan African region hosted more than 26% of the world's refugee population (UNHCR 2017). In 2017, the number of refugees in Africa rose to 6.2 million (UNHCR 2018). The increasing refugee crisis in Africa is complicated by the myriad economic, cultural, environmental, social and political challenges that the continent is already grappling with.

In this chapter, an overview of refugee health in the context of Africa is discussed, starting with a brief discussion of the refugee settlement patterns in Africa today, and a concise summary of health and health system challenges and policy discussions from the literature. Then the chapter considers the role of NGOs and advocacy groups in addressing health challenges among refugees, sharing success stories and winding up with recommendations. The chapter relies primarily on existing published peer reviewed literature, as well as grey literature mainly from UNHCR reports and press releases. In addition, this chapter is informed by the author's experiences working in Dadaab Refugee Complex, one of the world's biggest refugee settlements, in Kenya.

### **Refugee Settlement Patterns in Africa**

Most refugees in Africa are hosted in camps and settlements and in some cases are integrated within the host communities in urban or rural areas. Africa's biggest refugee camps have become home to thousands of refugees, who have turned to them to seek solace, shelter and some semblance of comfort after having been forced to flee their homes as a result of political strife, conflict, persecution, economic strain or natural disaster. There are many refugee camps in Africa, the biggest being Bidi Bidi in Uganda, Dadaab and Kakuma in Kenya, Yida in South Sudan, Katumba, Nyarugusu and Mishamo camps in Tanzania, and Pugnido in Ethiopia (Africa Facts 2018). Bidi Bidi is the second largest refugee camp in the world, located within the small Ugandan border town of Yumbe (Raptim Humanitarian Travel 2018). It is home to approximately 270,000 refugees, most of whom have fled the violence and upheaval in South Sudan.

Until 2009, the primary focus of UNHCR was provision of services to refugees in camps. The reality of displacement crises today is that at least half of all refugees settle in non-camp areas, including cities, villages, informal tented settlements and shanty towns (UNHCR 2015). They do so for many reasons. Refugees perceive that urban and other non-camp areas offer better freedom of movement, employment opportunities, and better provision of services such as education and health care. Refugees who settle in urban and other non-camp areas have better long term outcomes in terms of self-sufficiency than refugees in camps (UNHCR 2014). Camp settlement is inherently a short term and temporary solution to displacement. Yet many refugee crises in Africa are long term; thus their preference to integrate in host communities is not surprising.

### **Health Challenges Faced by Refugees**

Forced displacement typically increases the risks of health problems, particularly for vulnerable groups such as children, women, and the elderly. In most cases health problems arise owing to lack of basic necessities such as food, shelter and water, as well as reduced access to health care and loss of social networks and assets. Refugees arrive with a wide range of problems, presenting a complex array of health concerns (Sheikh and MacIntyre 2009). Refugees are often taken to remote places where social services are either scarce or lacking. For example, it is known that refugee camps are often crowded and have poor housing and sanitation conditions ripe for outbreak of infectious diseases (Atim 2013). The common health challenges faced by refugees in Africa are highlighted in this section.

#### ***Infectious Diseases***

Among refugees in Africa, infectious diseases are the leading cause of morbidity and mortality. Mass population movements, the destruction of health services, water systems and sanitation, malnutrition, and overcrowding in refugee camps are conducive to the spread of diseases among refugees and to host communities. In countries where children are already vulnerable to these diseases, migration

dramatically increases death rates, with those under five years at particular risk. Children in refugee settings are at risk of infectious diseases owing to lack of vaccination services. Common vaccine preventable diseases encountered among refugee populations include measles, polio, meningococcal meningitis, yellow fever, hepatitis A and cholera (Lam et al. 2015). The pattern of infectious diseases varies with the geographic origin of refugees and settlement in a host country with a less or more functional health system (Müller et al. 2018). The leading causes of morbidity and mortality in children younger than five years of age in the UNHCR refugee camps are malaria, pneumonia and diarrhoeal disease. In Africa, malaria accounts for 28% of health facility consultations among children under five, but diarrhoeal diseases are a leading cause of deaths (Hershey et al. 2011). In Dadaab refugee camp in Kenya, more than two-thirds of all deaths were reported to have been associated with diarrhoea (25%), pneumonia (24%) or fever (19%). Measles outbreaks also contributed 17% of all deaths (Polonsky et al. 2013). Other disease outbreaks reported in camps included: a cholera outbreak with 224 cases and four deaths, which occurred in Kakuma refugee camp in Kenya (Mahamud et al. 2011); and a hepatitis E outbreak, which occurred in 2012, with a total of 339 cases reported from camps in Kenya and refugee host villages (Ahmed et al. 2013). Rotavirus, a vaccine preventable disease causing severe diarrhoea in young children, was also quite common, with a quarter of children testing positive for rotavirus in Dadaab refugee camp (Ope et al. 2014).

### ***Mental Health***

Psychological distress, psychosomatic complaints and clinical mental disorders such as depression and post-traumatic stress disorder are more frequently encountered by refugees than host populations (Hollifield et al. 2002). This is mainly because many refugees go through a myriad of social challenges as they flee from their countries and experience severe psychological trauma. A study among Somali refugees in Melkadida camp in Ethiopia revealed that more than one-third (38.3%) of the refugees had depression. The main factors that were associated with depression among the refugees were female gender, being divorced, a history of previous displacement as a refugee, witnessing the murder of a family member or friend, lack of housing or shelter, and being exposed to a host of cumulative traumatic events. Similarly, in an internally displaced persons camp in South Darfur in Sudan, nearly one-third of respondents met criteria for major depressive disorder, 5% reported suicidal ideation and 2% reported personal suicide attempts over the previous year. Two per cent of households had a member who had committed suicide during the past year (Kim et al. 2007). Children are equally traumatized in refugee populations, and they often show a range of behaviours including poor school performance, behavioural problems, withdrawal from parents and other children, lack of confidence and trust, anxiety, depression, post-traumatic stress disorder (PTSD), sleep and eating disorders, bed wetting, sleep walking, speech problems and psychosomatic symptoms. This is attributable to the close link between a child's psychological health and that of the parents or primary caregiver. Parents who are traumatized and are not coping well have been shown to have a diminished ability to support their children physically and emotionally (NSW Refugee Health Service 2009). A study in Uganda reported that 32% of the Rwandese and 48.1% of the Somali refugees in Nakivale refugee settlement had PTSD (Onyut et al. 2009). Strengthening the clinical set-up and establishment of a good referral linkage with mental health institutions in refugee populations are thus a critical consideration for refugee populations (Feyera et al. 2015).

### ***Malnutrition***

Malnutrition is a major challenge in refugee populations, especially among vulnerable groups such as pregnant and lactating women, children under the age of five years, the sick and the elderly, as they have special nutritional needs. Although the World Food Programme (WFP) provides food rations

and numerous non-government organizations (NGOs) implement nutrition and health programmes (Doocy et al. 2011), food supply is often not sufficient to meet the needs of the populations, resulting in both macro- and micronutrient deficiencies. Thus both acute and chronic forms of malnutrition are common. A survey among refugees from South Sudan residing in the three camps in Ethiopia found the prevalence of global acute malnutrition among children aged 6–59 months to be 30%, twice the WHO emergency threshold of 15% (Andresen et al. 2014). A high incidence of micronutrient deficiency diseases has been reported in refugee camps, including pellagra (niacin deficiency), scurvy (vitamin C deficiency) and anaemia (iron deficiency) (Seal et al. 2007). Nearly half of the children in a refugee camp in Uganda had anaemia (Andresen et al. 2014). Iron deficiency is the most common type of anaemia among refugee children and women. In the children, this results from iron deficiency in the mother, prolonged exclusive breastfeeding, low iron intake, impaired absorption due to chronic episodes of diarrhoea, and parasitic infections (NSW Refugee Health Service 2009). Refugee children commonly experience severe dental caries and gum disease owing to substandard dental care and hygiene, and poor nutrition. Besides provision of food rations, advice about healthy eating, the advantages of breastfeeding over bottle feeding, and oral hygiene is important (NSW Refugee Health Service 2009). Malnutrition can contribute to more than half of child deaths in refugee camp settings (Toole and Waldman 1988). Addressing malnutrition among vulnerable groups within the refugee population would thus reduce mortality to a great extent.

### ***Experiences of Violence***

Incidents involving death and serious injury take place on a daily basis among refugees (Crisp 1999). Violence towards refugee women is too frequently tolerated, rarely investigated and seldom punished. Survivors of violence or abuse rarely have a viable legal institution to turn to for justice (Ward and Marsh 2006). International actors are paying scant attention to sexual- and gender-based violence (SGBV) in refugee settings. Urban refugee women and girls and those in refugee camps often grapple with SGBV. Research by the International Rescue Committee (IRC) indicates that one in five refugee and displaced women experience sexual violence, and most of them have no one to turn to for protection (IRC 2016). Among female urban refugees in Kampala, Uganda, 76.2% reported physical violence, and 63.3% reported sexual violence (Morof et al. 2014). In most refugee settlements, there is inadequate policing or the police lack the capacity for handling cases, since they lack examination rooms and kits to collect evidence from survivors. Moreover, in cases where evidence is collected, stations lack storage space, and in most cases evidence goes missing or is tampered with, becoming inadmissible in court. Court processes are lengthy. Female refugees are particularly vulnerable when they are separated from their husbands. Most adolescent girls end up in transactional sex work, early marriages, and trading sex for favours. Others may have temporary jobs, such as washing clothes, performing domestic chores, working in shops and construction sites, and selling produce and other wares in the market, which earn them meagre wages while still exposing them to frequent abuse (Pavanello 2010).

### ***Reproductive Health Problems***

Not only are refugee women vulnerable to abuse, but they are also vulnerable to hazardous working conditions and poor access to reproductive health care services. Complications during pregnancy and childbirth frequently occur among refugee women. In Sudan, internally displaced women have high pregnancy rates, low access to family planning and prenatal services, and high rates of unsupervised deliveries or deliveries assisted by non-professional attendants (Kim et al. 2007). Women also express limitations of sexual and reproductive rights—including rights to consensual marriage and sexual intercourse and decisions on the spacing and timing of children—which may negatively

affect their health. Since most women are heads of households, poor reproductive health and limited women's rights have a direct impact on the health of refugees (Kim et al. 2007). As a result, poor pregnancy outcomes are a common finding in refugee settings. The foetal death rate was 45.6 per 1,000 births, the neonatal mortality rate was 29.3 per 1,000 live births, and 22.4% of all live births were low birth weight (Jamieson et al. 2000). Pregnant sub-Saharan women present as an at-risk population related to poor prior health, co-existing disease, and cultural practices such as female genital mutilation. Nonetheless, principal pregnancy complications for this population include anaemia and high parity, rather than exotic disease. Higher rates of infant mortality and morbidity appear to persist following resettlement, and are not explained by maternal risk factors alone. Limited access to care is of concern (Carolan 2010).

### ***Health System Challenges***

Implementation of health care services specifically targeting refugees is not without its share of challenges. A study that was conducted to understand the health challenges facing refugees in 11 Southern African countries identified several issues. There were dominant challenges of availability and affordability of essential medicines as well as the acceptance of the refugees by the health care workers and the host communities. Some barriers specific to each country that were identified included but were not limited to language and cultural barriers, discrimination, policy and its implementation, health care workers' xenophobia, and refugee documentation (Zihindula et al. 2015). Diagnosis of diseases is more challenging for health care providers owing to language and social barriers, and the conflicts between the biomedical disease model and the health beliefs of refugees (Sheikh and MacIntyre 2009).

### ***Strain on the Health System of Host Countries***

Refugee inflows stretch domestic medical resources and divert health resources away from host communities (Atim 2013). A two-pronged health systems response to an influx of refugees has been applied: a parallel or an integrated health system. Parallel health services are new services developed and implemented by UN agencies and other NGOs specifically designed for refugees separate from services provided to local citizens by their own government. These may be short or long term, but they are different from national or local public services already in place. Refugee camps, for example, use a pure parallel-service model. Integrated services, by contrast, are those that the host country provides to refugees along with services to its citizens, sometimes with technical, financial or implementation support from donors, UN agencies, or NGOs (e.g., allowing refugees access to public schools and hospitals). Historically, humanitarian aid often relies on parallel-service provision because refugees often settle in remote places where government services are either non-existent or hard to access (Culbertson et al. 2016). Going forward, the international community is reassessing approaches to refugee assistance in humanitarian emergencies. This reassessment has two important components. The first is recognition that the parallel delivery of services assumes that most refugees live in camps, yet many refugees integrate into host communities; thus there is a need to create mechanisms and procedures that enable host countries to respond to the needs of refugees living among the urban and rural populations. Second, because refugees are interspersed with local communities and local authorities are critical components of any response, emergency humanitarian responses for refugees must be linked to host country development plans (Culbertson et al. 2016). It is increasingly becoming apparent that many services rendered to refugees require the support of line ministries, municipal authorities, the private sector, police, civil society actors and community groups in the host countries. Refugees attend local public schools, seek medical care in public clinics and hospitals, rent housing from the housing market, make use of water and sanitation systems, and



find jobs with local businesses which are under the management of host countries. This means that more actors need to work together rather than working in silos. Recent UNHCR assessments have echoed this need, especially the coordination of actors and their wider engagement in urban areas (Culbertson et al. 2016).

Uganda has successfully integrated refugee and host health services. The integrated health system is managed by the district local health service (DLHS) with financial and logistical support from both central government and the UNHCR. In general, the integrated system has contributed to improved geographic and temporal accessibility of health services, particularly for the rural host population. A further benefit was an enhancement in the harmonious relationship between refugee and host populations in the refugee-affected areas. However, the integration of health services presented challenges to the DLHS in the areas of sustainability and delivery of quality health services. Sustainability of operations in the integrated refugee health facilities was problematic because of limited human, financial, logistical and material resources. However, the continuous support of UNHCR and other donors is making inroads in strengthening the capacity of the integrated DLHS to provide effective, sustainable and quality health services (Orach and Brouwere 2005).

Local integration is a complex and gradual process by which refugees legally, economically, socially and culturally integrate as fully included members of the host society. As a legal process, refugees are granted a range of entitlements and rights that are broadly commensurate with those enjoyed by citizens. Over time the process should lead to permanent residence rights and, in some cases, the acquisition of citizenship in the country of asylum. Local integration requires efforts by all parties concerned. This includes preparedness on the part of refugees to adapt to the host society without having to forgo their own cultural identity. This also includes a corresponding readiness on the part of host communities and public institutions to welcome refugees and to meet the needs of a diverse population. Measuring the various dimensions of local integration from a statistical perspective remains a challenge, however, because of limited statistics on the naturalization of refugees in host countries (UNHCR 2014). In recent years, UNHCR has advocated that states either collect statistics on naturalized refugees separately or improve their national statistical systems to enable UNHCR and others to report on such data. These advocacy efforts have yielded positive results, with 31 countries reporting such statistics in 2013—the highest figure since UNHCR started collecting this data in 1997. These 31 included Canada, where the government shared statistics on naturalized refugees for the first time in 2013 (UNHCR 2014).

### **Success Stories**

One could argue that the presence of refugees could lead to improved health status in the local hosting community, as suggested by a study in Cameroon. The local host population invariably had access to improved health care services resulting from assistance programmes. The findings demonstrated that none of the evaluated maternal child health service indicators deteriorated with the presence of refugees—in fact, two of them improved: delivery in health facilities and completing the third dose of the diphtheria, pertussis and tetanus (DPT3) vaccine. It was also implicit that the presence of refugees in these areas could contribute to social and economic transformation. Increased cash and better health services would mean better health indicators (Tatah et al. 2016).

A study of refugee maternal mortality from 2008 to 2010 in ten countries (eight from sub-Saharan Africa) showed that mortality ratios were lower among refugees than among the host population. However, when mortality occurred, 78% of the time it followed delivery or abortion, and 56% of those deaths occurred within 24 hours. Delays in seeking and receiving care were more prevalent than delays in reaching care. In Kenya, delays in seeking or accepting care and provider failure to recognize the severity of the woman's condition were the most common avoidable contributing factors (Hynes et al. 2012).

While refugees often require help and support they can also benefit their adopted cities. Many urban refugees bring skills and experience and can make a positive economic contribution to the city. Somali refugees in Nairobi for example have created a thriving local economy around Eastleigh, a neighbourhood on the east side of the city (IRC 2012).

### **Role of NGOs and Advocacy Groups**

NGOs including advocacy groups have played a critical role in improving the health and well-being of refugees, especially when host government resources are not adequate. UNHCR Ethiopia works with its partners the Administration for Refugee and Returnee Affairs (ARRA), the Development and Inter-Church Aid Commission (DICAC) and the International Organization for Migration (IOM) for refugee status determination to ensure that all refugees are able to fulfil their rights in accessing primary health care and essential life-saving secondary and tertiary health services through the national health system. UNHCR and ARRA liaise with authorities to continue making health services available at similar or less cost to that of nationals or subsidized where necessary. In turn, UNHCR supports and facilitates integration into and the strengthening of the public health system. This may include direct funding or indirect support via partners. UNHCR, ARRA, the Ministry of Health and partners assess, monitor and evaluate the health, nutritional, educational and economic status of refugees, ensuring needs are met in line with accepted standards and that quality services are available and accessible. Since the existing government health institutions in the country demand service charges, the health partner DICAC has made contractual agreements with many government and private hospitals and clinics. These activities necessitate close collaboration with the government of Ethiopia in budgeting, developing treatment guidelines, support to the national institutions in terms of training and equipment, and referral mechanisms (Morand and Leo 2015).

While UNHCR's primary purpose is to safeguard the rights and well-being of refugees, the organization's ultimate goal is to help find durable solutions that will allow these individuals to rebuild their lives in dignity. UNHCR is mandated to provide international protection and seek 'permanent solutions to the problem of refugees'. In exercising its mandate for durable solutions, UNHCR facilitates the voluntary repatriation of refugees, their assimilation within new national communities, or their resettlement to third countries (UNHCR 2014). As it works towards this, there is a need to pay the utmost attention to the health and well-being of the refugees.

In 2014, the Nairobi Office initiated enrolment of vulnerable refugees to access the National Health Insurance Fund (NHIF). The fund significantly allows refugees to access national health services and have part of their medical fees covered by the fund. The first refugees enrolled in the NHIF were Albert Einstein German Academic Refugee Initiative (DAFI) scholars in Kenya, since medical insurance was a prerequisite of university attendance. By using the NHIF for its 200 current students, the DAFI programme in Kenya saved US\$19,000 and was able to support 37 more students for university education. Although this initiative has significantly reduced the health burden for UNHCR and made it possible for refugees to access health facilities, it should be noted that UNHCR continues to underwrite the US\$12 subscriptions. Nevertheless, the enrolment proves that national services that are presumed only to be available to the country's citizens can be accessed by refugees (Morand and Leo 2015).

Training of health workers to improve refugee health services is important. A mixed methods study to assess change in the knowledge of community- and facility-based health workers in two internally displaced person camps in South Sudan showed that knowledge and attitudes toward key essential practices, such as the use of a partograph to assess labour progress, early initiation of breastfeeding, skin-to-skin care and weighing the baby, improved among skilled birth attendants. Despite challenges in conflict-affected settings, conducting training has the potential to increase



health workers' knowledge in neonatal health post-training. The humanitarian community should reinforce this knowledge with key actions to shift cultural norms that expand the care provided to women and their newborns in these contexts.

## **Conclusions and Recommendations**

Several international conventions and protocols establish the duties of states in terms of treatment of refugees. These include: the Convention Relating to the Status of Stateless Persons; the Geneva Conventions; the Statute of the Office of the United Nations High Commissioner for Refugees; and the Universal Declaration of Human Rights, article 14. These documents establish international standards for governments and private organizations. These standards, however, are rarely enforced (Persky and Zuhurova 2000), resulting in many challenges for refugee populations. There is a need to renew commitment to these standards in many countries.

Health of refugees can be significantly improved in various ways. Some of these ways have been suggested as follows. Humanitarian aid organizations need to monitor the refugee health service providers closely to monitor health conditions as well as ensure the quality of health services provision. One way of doing this could be by conducting evaluation research in these health services. An example of this is a study that was carried out by the African Population and Health Research Center (APHRC) and the London School of Hygiene and Tropical Medicine (LSHTM) to evaluate a model of care for survivors of gender-based violence within the Dadaab refugee camp in Kenya. Another way could be by establishing electronic health information systems for refugees. UNHCR has led by example (Haskew et al. 2010).

Communication and community engagement are a key element of successful vaccine delivery, but are of critical value in vaccine delivery in conflict and humanitarian-emergency settings. Advocacy with local traditional and religious leaders, information sharing with communities, training of local residents as vaccinators, and building community mobilization networks with support from community 'gatekeepers' may help shed light on the felt needs of the communities and build trust between the community and the programme. Finding solutions to some of these needs, including working with other development partner agencies, may be key to gaining trust, interest, and access to the community. In Northern Nigeria, the Volunteer Community Mobilizer programme, a focused initiative that recruited and trained local community women as social mobilizers and vaccination workers, is considered to have bolstered participation in house-to-house polio and other routine immunization programmes, especially in security-compromised and hard-to-reach communities (Nnadi et al. 2017).

While effective delivery of immunization services to populations in these settings may be fraught with varied levels of risk, experience in several geographical settings indicates that, with a good understanding of the nuances of the conflict and a great deal of operational flexibility, reaching and immunizing eligible populations in these settings may continue to be operationally viable. Key strategies that have been used in the polio eradication programme include security assessments, negotiations with key actors, use of geographic information systems technology, close community engagement and coordination with other humanitarian relief activities, and flexibility around vaccine scheduling and dosing options (Nnadi et al. 2017).

Insecurity compromises access to basic health care services and often means that multiple birth cohorts may have missed age-appropriate vaccines. Prioritizing flexibility around age and other eligibility criteria for receiving the vaccines is a key strategy for preventing outbreaks among populations living in conflict and humanitarian-emergency settings. These decisions are usually informed by epidemiological characterization of potential disease outbreaks and by the immunity profile of the population (Nnadi et al. 2017).

Close collaboration with the refugee associations is equally important so as to listen carefully to their concerns regarding the services, introduce the referral procedures and build their trust in the government system, including for the prescription of generic drugs; reportedly they all look like Panadol (Morand and Leo 2015).

Established camps will often have a clinic or other facility in which routine immunization services can be delivered. New or arriving refugees are screened for vaccination status, and catch-up vaccination may be provided. Religious institutions, including mosques, temples, churches and other places of worship, and traditional or cultural gatherings have served as useful access points to populations cut off from sites for vaccine delivery in conflict settings (Nnadi et al. 2017).

The Sustainable Development Goals (SDGs) encourage states not to 'leave behind' populations who have been forcibly displaced by war and other extreme hardships in development work. Such forced migrants include people who are internally displaced to areas within their own country where different languages, ethnic groups and customs may predominate, as well as refugees who have left their country and are seeking protection from another (Palmer et al. 2017).

Another area of concern is the focus of assistance, whether the assistance is targeted only at the refugees or at host communities as well. According to interviewees, these differences are evident in the competing approaches of UNHCR, the governments and others. UNHCR's approach, in line with its mandate, has been to direct its resources in support of refugees. Others have argued that supporting host communities to expand their provision of education, health or sanitation is a more sustainable and effective way to assist refugees; it also alleviates some of the political problems that might otherwise accompany refugee assistance (Culbertson et al. 2016). Finally, it is necessary to invest in research to fill the gap in understanding of the problems facing refugees to more effectively inform interventions (IRC 2012).

## References

- Africa Facts. 2018. Africa's biggest refugee camps. Retrieved from <https://africa-facts.org/africas-biggest-refugee-camps/>
- Ahmed, J.A., Moturi, E., Spiegel, P., Schilperoord, M., Burton, W., Kassim, N.H., and Navarro-Colorado, C. 2013. Hepatitis E outbreak, Dadaab refugee camp, Kenya, 2012. *Emerging Infectious Diseases*, 19(6), 1010.
- Andresen, E., Bilukha, O.O., Menkir, Z., Gayford, M., Kavosa, M., Wtsadik, M., and Shahpar, C. 2014. Notes from the field: Malnutrition and elevated mortality among refugees from South Sudan—Ethiopia, June–July 2014. *Morbidity and Mortality Weekly Report*, 63(32), 700–701.
- Atim, G. 2013. The impact of refugees on conflicts in Africa. *IOSR Journal of Humanities and Social Science*, 14(2), 4–9.
- Carolan, M. 2010. Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: A review of the literature. *Midwifery*, 26(4), 407–414.
- Crisp, J. 1999. *A state of insecurity: The political economy of violence in refugee-populated areas of Kenya*. New Issues in Refugee Research. Retrieved from [www.unhcr.org](http://www.unhcr.org)
- Culbertson, S., Olinger, O., Baruch, B., and Blum, I. 2016. *Rethinking coordination of services to refugees in urban areas: Managing the crisis in Jordan and Lebanon*. Santa Monica, CA: RAND Corporation.
- Doocy, S., Tappis, H., Haskew, C., Wilkinson, C., and Spiegel, P. 2011. Performance of UNHCR nutrition programs in post-emergency refugee camps. *Conflict and Health*, 5(23).
- Feyera, F., Mihretie, G., Bedaso, A., Gedle, D., and Kumera, G. 2015. Prevalence of depression and associated factors among Somali refugees at Melkadida camp, Southeast Ethiopia: A cross-sectional study. *BMC Psychiatry*, 15(171).
- Haskew, C., Spiegel, P., Tomczyk, B., Cornier, N., and Hering, H. 2010. A standardized health information system for refugee settings: Rationale, challenges and the way forward. *Bulletin of the World Health Organization*, 88(10), 792–794.
- Hershey, C.L., Doocy, S., Anderson, J., Haskew, C., Spiegel, P., and Moss, W.J. 2011. Incidence and risk factors for malaria, pneumonia and diarrhea in children under 5 in UNHCR refugee camps: A retrospective study. *Conflict and Health*, 5(1), 24.

- Hollifield, M., Warner, T.D., Lian, N., Krakow, B., Jenkins, J.H., Kesler, J., Stevenson, J., and Westermeyer, J. 2002. Measuring trauma and health status in refugees: A critical review. *JAMA*, 288(5), 611–621.
- Hynes, M., Sakani, O., Spiegel, P., and Cornier, N. 2012. A study of refugee maternal mortality in 10 countries, 2008–2010. *International Perspectives on Sexual and Reproductive Health*, 38(4), 205–213.
- IRC (International Rescue Committee). 2012. Urban refugees. Retrieved from [www.rescue-uk.org/sites/default/files/document/986/201112urbanrefsharechoadvocacyevent0.pdf](http://www.rescue-uk.org/sites/default/files/document/986/201112urbanrefsharechoadvocacyevent0.pdf)
- IRC (International Rescue Committee). 2016. Clinical care for survivors of gender-based violence at the International Rescue Committee. Retrieved from [www.rescue.org/resource/clinical-care-survivors-gender-based-violence-international-rescue-committee](http://www.rescue.org/resource/clinical-care-survivors-gender-based-violence-international-rescue-committee)
- Jamieson, D.J., Meikle, S.F., Hillis, S.D., Mtsuko, D., Mawji, S., and Duerr, Ann. 2000. An evaluation of poor pregnancy outcomes among Burundian refugees in Tanzania. *Journal of the American Medical Association*, 283(3), 397–402.
- Kim, G., Torbay, R., and Lawry, L. 2007. Basic health, women's health, and mental health among internally displaced persons in Nyala Province, South Darfur, Sudan. *American Journal of Public Health*, 97(2), 353–361.
- Lam, E., McCarthy, A., and Brennan, M. 2015. Vaccine-preventable diseases in humanitarian emergencies among refugee and internally-displaced populations. *Human Vaccines and Immunotherapeutics*, 11(11), 2627–2636.
- Mahamud, A.S., Ahmed, J.A., Nyoka, R., Auko, E., Kahi, V., Ndirangu, J., and Breiman, R.F. 2011. Epidemic cholera in Kakuma refugee camp, Kenya, 2009: The importance of sanitation and soap. *Journal of Infection in Developing Countries*, 6(3), 234–241.
- Morand, M. and Leo, C.C. 2015. *Building communities of practice for urban refugees*. Africa Regional Workshop Report. Geneva: UNHCR.
- Morof, D.F., Sami, S., Mangeni, M., Blanton, C., Cardozo, B.L., and Tomczyk, B. 2014. A cross-sectional survey on gender-based violence and mental health among female urban refugees and asylum seekers in Kampala, Uganda. *International Journal of Gynecology and Obstetrics*, 127(2), 138–143.
- Müller, M., Khamis, D., Srivastava, D., Exadaktylos, A.K., and Pfortmueller, C.A. 2018. Understanding refugees' health. *Seminars in Neurology*, 38(2), 152–162.
- Nnadi, C., Etsano, A., Uba, B., Ohuabunwo, C., Melton, M., Nganda, G., Esapa, L., Bolu, O., Mahoney, F., Vertefeuille, J., Wiesen, E., and Durry, E. 2017. Approaches to vaccination among populations in areas of conflict. *Journal of Infectious Diseases*, 216(Suppl 1), S368–S372.
- NSW Refugee Health Service. 2009. Fact sheet 8: Refugee children. Retrieved from [www.swslhd.health.nsw.gov.au/refugee/pdf/Resource/FactSheet/FactSheet\\_08.pdf](http://www.swslhd.health.nsw.gov.au/refugee/pdf/Resource/FactSheet/FactSheet_08.pdf)
- Onyut, L.P., Neuner, F., Ertl, V., Schauer, E., Odenwald, M., and Elbert, T. 2009. Trauma, poverty and mental health among Somali and Rwandese refugees living in an African refugee settlement—An epidemiological study. *Conflict and Health*, 3(1), 6.
- Ope, M., Ochieng, S.B., Tabu, C., and Marano, N. 2014. Rotavirus enteritis in Dadaab refugee camps: Implications for immunization programs in Kenya and resettlement countries. *Clinical Infectious Diseases*, 59(1), v–vi.
- Orach, C.G. and Brouwere, V.D. 2005. Integrating refugee and host health services in West Nile districts, Uganda. *Health Policy and Planning*, 21(1), 53–64.
- Palmer, J.J., Okello, R., and Kansiime, F. 2017. Including refugees in disease elimination: Challenges observed from a sleeping sickness programme in Uganda. *Conflict and Health*, 11(22).
- Pavanello, S., Elhawary, S., and Pantuliano, S. 2010. *Hidden and exposed: Urban refugees in Nairobi, Kenya*. HPG Working Paper. London: Overseas Development Institute.
- Persky, L. and Zukhurova, Z. 2000. Health of refugees and internally displaced peoples. *Review Digest: Human Rights and Health*, 1(1), 130–142.
- Polonsky, J.A., Ronsse, A., Ciglencecki, I., Rull, M., and Porten, K. 2013. High levels of mortality, malnutrition, and measles, among recently-displaced Somali refugees in Dagahaley camp, Dadaab refugee camp complex, Kenya, 2011. *Conflict and Health*, 7(1), 1.
- Raptim Humanitarian Travel. 2018. World's largest refugee camps in 2018. Retrieved from [www.raptim.org/largest-refugee-camps-in-2018/](http://www.raptim.org/largest-refugee-camps-in-2018/)
- Refugee Council. 2018. The truth about asylum: Who's who. Retrieved from [www.refugeecouncil.org.uk/policy\\_research/the\\_truth\\_about\\_asylum/the\\_facts\\_about\\_asylum](http://www.refugeecouncil.org.uk/policy_research/the_truth_about_asylum/the_facts_about_asylum)
- Seal, A.J., Creeke, P.I., Mirghani, Z., Abdalla, F., McBurney, R.P., Pratt, L.S., Brookes, D., Ruth, L.J., and Marchand, E. 2005. Iron and vitamin A deficiency in long-term African refugees. *Journal of Nutrition*, 135(4), 808–813.
- Seal, A.J., Creeke, P.I., Dibari, F., Cheung, E., Kyroussis, E., Semedo, P., and van den Briel, T. 2007. Low and deficient niacin status and pellagra are endemic in postwar Angola. *American Journal of Clinical Nutrition*, 85(1), 218–224.

- Sheikh, M. and MacIntyre, C.R. 2009. The impact of intensive health promotion to a targeted refugee population on utilisation of a new refugee paediatric clinic at the children's hospital at Westmead. *Ethnicity and Health*, 14(4), 393–405.
- Tatah, L., Delbiso, T.D., Rodriguez-Llanes, J.M., Gil Cuesta, J., and Guha-Sapir, D. 2016. Impact of refugees on local health systems: A difference-in-differences analysis in Cameroon. *PLOS ONE*, 11(12), e0168820. doi: 10.1371/journal.pone.0168820.
- Toole, M.J. and Waldman, R. 1988. The association between inadequate rations, undernutrition prevalence, and mortality in refugee camps: Case studies of refugee populations in Eastern Thailand, 1979–1980 and Eastern Sudan, 1984–1985. *Journal of Tropical Pediatrics*, 34, 218–224.
- UN (United Nations). 2001. *Guiding principles on internal displacement*. New York: United Nations.
- UNHCR (United Nations High Commissioner for Refugees). 2010. *Convention and Protocol Relating to the Status of Refugees*. Retrieved from [www.unhcr.org/3b66c2aa10.html](http://www.unhcr.org/3b66c2aa10.html)
- UNHCR (United Nations High Commissioner for Refugees). 2014. *UNHCR global trends 2013: War's human cost*. Geneva: UNHCR.
- UNHCR (United Nations High Commissioner for Refugees). 2015. *Global trends: Forced displacement in 2014: World at war*. Retrieved from [www.unhcr.org/statistics/country/556725e69/unhcr-global-trends-2014.html](http://www.unhcr.org/statistics/country/556725e69/unhcr-global-trends-2014.html)
- UNHCR (United Nations High Commissioner for Refugees). 2016. Regional summaries, Africa. In *Global report 2016* (pp. 50–61). Geneva: UNHCR.
- UNHCR (United Nations High Commissioner for Refugees). 2017. *Africa*. Retrieved from [www.unhcr.org/africa.html](http://www.unhcr.org/africa.html)
- UNHCR (United Nations High Commissioner for Refugees). 2018. *Global trends: Forced displacement in 2017*. Retrieved from [www.unhcr.org/5b27be547.pdf](http://www.unhcr.org/5b27be547.pdf)
- Ward, J. and Marsh, M. 2006. Sexual violence against women and girls in war and its aftermath: Realities, responses and required resources. In *Symposium on Sexual Violence in Conflict and Beyond*, Vol. 21, p. 23.
- Zihindula, G., Meyer-Weitz, A., and Akintola, O. 2015. Access to health care services by refugees in Southern Africa: A review of literature. *Southern African Journal of Demography*, 16(1), 7–35.